

Anil Kapoor, MD, FRCSC

Department of Surgery (Urology)
and Oncology, McMaster
University, Hamilton, ON, Canada,
and CUAJ Associate Editor

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The headlines are clear: “No patient who presents with metastatic kidney cancer benefits from surgical removal of their primary kidney tumour.” This dramatic statement was the conclusion of the CARMENA trial findings presented at the American Society of Clinical Oncology (ASCO) meeting in June 2018, stating that cytoreductive nephrectomy should no longer be part of the standard of care for patients with metastatic renal cell carcinoma (mRCC). This trial randomized patients with mRCC with intermediate- and poor-risk criteria to one of two arms — sunitinib alone or cytoreductive nephrectomy followed by sunitinib. In the final analysis, the median overall survival (OS) was longer in the sunitinib alone arm. As a result of this trial conclusion, which spread quickly throughout the kidney cancer community, the rates of cytoreductive nephrectomy have plummeted across Canada. But are these conclusions absolute? Are there any patients with mRCC who would benefit from surgery on their kidney tumour?

In this issue of the *CUAJ*, Mason et al provide guidance to answer these questions through the The Kidney Cancer Network of Canada (KCRNC) consensus statement on the role of cytoreductive nephrectomy for patients with mRCC. The KCRNC, founded by Dr. Michael Jewett from the University of Toronto, is a network of researchers committed to the facilitation of kidney cancer research in Canada, and includes clinical experts, researchers, and patients. The KCRNC works closely with Kidney Cancer Canada to promote and fund kidney cancer research across Canada, and produces periodic consensus statements to guide clinicians in the management of their kidney cancer patients.

The role of cytoreductive nephrectomy has become controversial in the management of mRCC; however, it is clear that selected patients with mRCC would certainly benefit from nephrectomy; this KCRNC consensus provides that guidance. Not all patients should be painted with the same brush that nephrectomy is not indicated. Patients that may benefit from cytoreductive nephrectomy include those patients with good performance status, young age, no systemic symptoms, relatively limited burden of disease, favourable-risk status, and select intermediate-risk patients. Patients with poor-risk status probably would not benefit from cytoreductive nephrectomy.

An important caveat in this controversy is that the current systemic management has evolved quickly such that tyrosine kinase inhibitors (TKIs), like sunitinib, are no longer the standard treatment for intermediate- and poor-risk patients; the immuno-oncology (IO) class of therapies is the new standard, either in combination with another IO drug or a TKI. (Stay tuned for an upcoming updated KCRNC consensus on these new therapies.) So is this new CARMENA study already irrelevant? The KCRNC recommends that such patients be discussed in multidisciplinary clinics (urologist, medical oncologist, radiation oncologist, nursing, radiologist, and pathologist) if possible to optimize care for your kidney cancer patient.

Correspondence: Dr. Anil Kapoor, Department of Surgery (Urology) and Oncology, McMaster University, Hamilton, ON, Canada; akapoor@mcmaster.ca